JOINT LEGISLATIVE SUNSET REVIEW COMMITTEE FINDINGS AND RECOMMENDATIONS

Review and Evaluation of the Respiratory Care Board

Report to the
Department of Consumer Affairs

APRIL, 1998

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1.

OVERVIEW OF THE CURRENT REGULATORY PROGRAM OF THE RESPIRATORY CARE BOARD OF CALIFORNIA

BACKGROUND AND DESCRIPTION OF THE PROFESSION AND BOARD

The Respiratory Care Board (board), originally established as the Respiratory Care Examining Committee, was created by the Legislature in 1982 to protect a vulnerable patient population from the unqualified practice of respiratory care. The nine-member board is responsible for enforcing federal and state laws pertaining to the practice of respiratory care. The board regulates a single category of health care workers—respiratory care practitioners (RCPs). RCPs are specialized health care workers, who work under the supervision of medical directors and are involved in the prevention, diagnosis, treatment, management, and rehabilitation of problems affecting the heart and lungs. As stated in its sunset report, the board and its 14-member staff see their mission as:

> *Protecting the public from the unauthorized or the unqualified practice of respiratory care and from negligent or unprofessional conduct by persons licensed to practice in the profession.*

The law governing RCPs, as set forth in Sections 3700-3777 of the Business and Professions Code, is a practice act that requires licensure for individuals performing respiratory care. With the exception of various fee increases and a current proposal to increase the education standards for RCPs, the Respiratory Care Practice Act has remained relatively unchanged since its inception. The practice of respiratory care is regulated through licensure in 35 states. Seven states certify RCPs through title regulation. The remaining states do not regulate the profession.

The board's activities fall into the following four program areas:

- ***Licensure:*** The board regulates a total of about 19,500 RCPs. The board issued 705 licenses and renewed over 13,000 licenses in 1996-97. Over 50 percent of board licensees were grandfathered into licensure in 1985 under the board's enabling legislation. Figure 1 provides board-licensing data for the past four years.

Figure 1 – Licensing data

LICENSING DATA FOR RCPs	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Total Licensed Grandfathered (Active)	Total: **17,168** 7,545	Total: **17,983** 7,220	Total: **18,734** 6,871	Total: **19,434** 6,416
Applications Received	Total: **1,000**	Total: **882**	Total: **781**	Total: **730**
Applications Denied	Total**:** **38**	Total: **76**	Total: **66**	Total: **25**
Licenses Issued	Total: **962**	Total: **806**	Total: **715**	Total: **705**
Renewals Issued	Total: **13,049**	Total: **13,289**	Total: **13,511**	Total: **13,673**
Statement of Issues Filed	Total: **26**	Total: **72**	Total: **48***	Total: **45****
Statement of Issues Withdrawn	Total: **1**	Total: **1**	Total: **0**	Total: **0**
Licenses Denied	Total: **8**	Total: **10**	Total: **12**	Total: **11**
Licenses Granted	Total: **10**	Total: **20**	Total: **43**	Total: **55**

***Includes 11 prestipulated settlements.
****Includes 15 prestipulated settlements.

- ***Examination*:** The board uses a written national licensing examination as the testing requirement for licensure. The examination, which is offered three times a year at five test centers throughout California, tests for entry level knowledge, skill, and ability in applicants for licensure.

- ***Continuing Education:*** In an attempt to ensure the continuing competency of RCPs, the board requires licensees to complete 15 hours of continuing education for each two-year license renewal period.

- ***Enforcement*:** The board places a high priority on enforcing the practice act for RCPs and dedicates the majority of its budget to the enforcement program. The board focuses its efforts on denying licenses to applicants who are deemed unsafe to practice. In 1996-97, the board spent 84 percent of its budget—the highest among all boards under review this year—on enforcement activity.

The board is comprised of nine members, six professionals and three public. The professional members are split among four respiratory care practitioners and two physicians. Appointments to the board are split evenly among the Assembly, the Senate, and the Governor.

BUDGET AND STAFF

Current Fee Schedule and Range

The board's main source of revenue is the RCP biennial license renewal fee of $200, which generates approximately 60 percent of the board's budget. Additional revenue comes from a variety of applicant and licensee fees. Figure 2 shows the board's current fee schedule. Due to the board's projected budget deficit situation for the current and future years, the board is proposing a fee increase.

Figure 2 – Fee Schedule

Fee Schedule	Current Fee	Statutory Limit
Application Fee	$200	$200
Exam Fee	$100	Actual Costs
Original License Fee	$200	$200
Biennial Renewal Fee	$200	$200
Inactive Renewal Fee	$200	$200

Revenue and Expenditure History

Board revenues are projected to be $1.8 million in the current year, nearly even with 1996-97 revenues. The board expects to spend $2.1 million in 1997-98 from the Respiratory Care Fund. As shown in Figure 3, this is $85,000, or 4 percent, more than actual 1996-97 expenditures. The largest increase has been in the area of enforcement activity.

As Figure 3 also shows, board expenditures are projected to be greater than revenues for the current year, leaving the board with a $320,000 deficit. This deficit trend is projected to continue into the next year. These projections do not reflect an unpaid balance of $246,000 owed to the Attorney General (AG) for services in 1994-95 and 1995-96. As a result of the board's historical fiscal situation, the board has depleted its budget for AG prosecution services eight months into the fiscal year for the past two years.

The board is proposing a number of actions to rectify its budget situation. Among them are a fee increase and a loan to address the current-year deficit.

Figure 3 – Revenues and Expenditures

	ACTUAL	PROJECTED

	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97	FY 1997/98	FY 1998/99
REVENUES						
Licensing Fees	$1,296,320	$1,320,022	$1,467,980	$1,541,931	$1,647,060	$1,726,620
Cost Recovery	$14,293	$28,623	$45,670	$120,932	$130,000	$132,600
Interest	$21,000	$23,000	$20,269	$25,744	$5,000	$5,000
TOTALS	**$1,331,613**	**$1,371,645**	**$1,533,919**	**$1,886,299**	**$1,802,060**	**$2,059,512**
EXPENDITURES						
Personnel Services	$382,986	$494,315	$537,817	$546,033	$632,543	$645,194
Operating Expenses	$515,661	$459,363	$488,328	$463,094	$526,752	$537,287
Investigations*	$310,444	$181,328	$166,404	$634,727	$571,705	$500,000
Attorney General**	$275,479	$250,479	$272,772	$300,923	$296,000	$301,920
Office of Admin. Hearing	$46,721	$60,261	$91,638	$88,662	$90,000	$91,800
Evidence/Witnesses	$14,306	$9,348	$2,656	$3,420	$5,000	$5,100
TOTALS	**$1,545,597**	**$1,455,094**	**$1,559,615**	**$2,036,859**	**$2,122,000**	**$2,081,301**

*FY 1996/97 expenditures includes $197,000 for probation, plus $255,832 rolled over from FY 1994/95, plus $180,946 for current-year estimated services. FY 1997/98 expenditures includes $197,000 for probation, plus $238,766 rolled over from FY 1995/96, plus $135,939 for current-year estimated services.

**Does not reflect outstanding balance owed to the Office of Attorney General in the amount of $246,326 for services performed in FY 1994/95 ($144,757) and FY 1995/96 ($101,569).

Expenditures by Program Component

Figure 4 shows board expenditures by program component for the past four years since 1993-94. As indicated, spending on enforcement has increased by 38 percent. The board annually spent, on average, 80 percent of its budget on enforcement from 1993-94 to 1996-97, the highest enforcement expenditures, on a percentage basis, of all health care boards currently under review.

The board estimates that current-year spending on enforcement will account for 84 percent of its budget ($1.7 million). In comparison and based on available data, all other health boards spent, on average, about 53 percent of their budgets on enforcement in 1996-97. The board attributes spending a much higher proportion of its budget on enforcement to the fact that RCP applicants and licensees have an unusually high incidence of criminal convictions and substance abuse problems. Specifically, the board states that, unlike any other board, approximately 30 percent of applicants investigated have either criminal conviction or substance abuse histories.

Figure 4 – Expenditures by Component

EXPENDITURES BY PROGRAM COMPONENT	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97	Average % Spent by Program
Enforcement	$1,244,200	$1,137,249	$1,232,823	$1,719,693	**84%**

Licensing & Exam	$208,319	$211,766	$210,293	$201,277	**10%**
Executive	$93,078	$106,079	$116,499	$115,889	**6%**
TOTALS	**$1,545,597**	**$1,455,094**	**$1,559,615**	**$2,036,859**	**100%**

Fund Condition

As summarized in Figure 5 and stated above, the board's expenditures will begin to exceed revenues in the current year. Based on this revenue/expenditure plan, the board is projecting that the deficit will continue into 1998-99. The board's historical fund condition indicates that the board has maintained less than a two-month reserve since 1995-96. Generally, a prudent reserve of three months operating costs is recommended for all boards. As mentioned above, this budget data does not reflect the outstanding balance of nearly $250,000 owed for 1994-95 and 1995-96 AG services.

In response to the budget situation, the board is proposing an increase in renewal fees to be effective 1999. In addition to increasing fees, the board must reduce program activities to restore a sufficient operating reserve.

Figure 5 —Fund Condition

ANALYSIS OF FUND CONDITION	FY 1995/96	FY 1996/97	FY 1997/98 (Projected)	FY 1998/99 (Projected)
Total Reserves, July 1	$199,393	$214,837	$92,499	($177,859)
Total Rev. & Transfers	$1,467,980	$1,541,931	$1,647,060	$1,726,620
Total Resources	$1,670,772	$1,958,844	$1,764,559	$1,749,053
Total Expenditures	$1,455,935	$1,866,345	$1,942,418	$1,898,127
Reserve, June 30	$214,837	$92,499	($177,859)	($149,074)
MONTHS IN RESERVE	**1.38**	**0.57**	**-1.12**	**-0.94**

LICENSURE REQUIREMENTS

Education, Experience and Examination Requirements

To be a licensed respiratory care practitioner in California, applicants generally must be 18 years old, complete an approved one- or two-year respiratory care program with 600 hours of clinical practice (there is no statutory requirement regarding minimum number of clinical hours), and pass a written national examination. In response to a growing enforcement caseload, the board is proposing an increase in the educational standards for RCP licensure by requiring a minimum of two years of school and 800 hours of clinical practice.

Over 700 candidates take the national board examination in California each year. The National Board for Respiratory Care is the board's vendor for development and administration of the Certified Respiratory Therapy Technician examination, which is used as the licensing examination for RCPs. As Figure 6 shows, the average annual passage rate for the RCP examination from 1993-94 to 1996-97 was 65 percent. The last occupational analysis to validate the examination was

conducted in 1992. According to the board, the exam contractor is in the process of validating the examination for 1999.

Figure 6 – Examination Pass Rate

CALIFORNIA EXAMINATION PASS RATE				
	FY 1993/94	**FY 1994/95**	**FY 1995/96**	**FY 1996/97**
CANDIDATES	1164	1044	934	792
PASS %	68%	66%	69%	68%

The board offers the RCP examination three times a year at five different sites. As Figure 7 shows, as of the last fiscal year, the board reduced post-examination application issuance time by 38 percent and now takes approximately 30 days to issue licenses after examination.

Figure 7 — Application Processing Time

AVERAGE DAYS TO RECEIVE LICENSE	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Application to Examination	*	*	*	*
Examination to Issuance	53	69	41	33
Total Average Days	**	**	**	**

***Data not reported by the board.
**Unable to calculate due to missing data.

Continuing Education/Competency Requirements

To help ensure ongoing licensee competency, the board requires 15 hours of continuing education (CE) coursework for each two-year renewal period. The CE courses must be relevant to respiratory care with the requirement that at least two-thirds of the hours be directly related to clinical practice. Due to budget constraints, the board has not exercised its authority to approve courses or providers. Rather, the board has decided that the responsibility for determining course acceptability rests with licensees. However, the board does randomly audit about 5 percent of renewing licensees each year for CE compliance.

In comparison to the other boards currently under review, the board has not implemented certain safeguards to assure the quality of its continuing education program. The absence of course approval may call into the question the ability of the board to assure ongoing licensee competency. The board may want to consider using peer review committees to ensure that its CE requirements are relevant to ongoing competency.

Comity/Reciprocity With Other States

It appears that the board has no provisions for the temporary licensing of individuals licensed by other states or countries. *All* applicants are subject to California licensure requirements.

The board does not offer licensure through reciprocity for individuals licensed as RCPs in other states. Rather, licensed individuals from other states applying for California licensure must meet all of the state's licensing requirements, including a license in good standing. However, the board does accept passage of an examination equivalent to the national examination utilized in California.

ENFORCEMENT ACTIVITY

Enforcement Program Overview

According to the board, its main enforcement goal is the prevention of patient abuse and negligent care. To accomplish this, the board takes a proactive approach to enforcement by conducting rigorous applicant investigations and taking extensive pre-licensure disciplinary action against applicants.

The board receives, on average, 391 enforcement complaints per year from either internal or external sources, and has 6.5 staff positions dedicated to enforcement. In contrast to most enforcement programs where the majority of complaint caseload comes from consumer complaints, nearly all of the complaints against board licensees (over 70 percent) are internally generated from applicant criminal conviction histories. Specifically, these complaints are based on initial or updated criminal identification information reports (better known as rap sheets) obtained from the Department of Justice (DOJ) or the Federal Bureau of Investigation (FBI) and reviewed by the board at the time of initial application and, if warranted, at license renewal based on renewal application conviction affidavits and DOJ reports of subsequent criminal activity.

According to the board, the regulation of the respiratory care profession currently poses a unique challenge because: (1) nearly 10,000 licensees were grandfathered into licensure without background checks at implementation of the Respiratory Care Practice Act in 1982 and (2) a high incidence of substance abuse and criminal activity among applicants for licensure (30 percent of applicants investigated). However, the enforcement workload related to grandfathered licensees should be stabilizing and decreasing after 15 years of board regulatory activity.

The board is authorized to deny licensure or grant conditional licensure to applicants who have been convicted of crimes "substantially related" to the practice of respiratory care. The link between substantially related crimes and the ability to practice is left to the discretion of the board. For example, board regulations allow the board to issue probationary licenses to applicants with one or more driving under the influence (DUI) convictions within 1-2 years or two or more DUIs within five years.

Figure 8 summarizes the board's enforcement activities over the past four years. As the table shows in the complaints filed by type category, the largest number of complaints filed (over 60 percent of formal and informal complaints investigated in 1996-97) appear to be in the area of personal conduct, whereas less than 1 percent were in the area of incompetence/negligence. Because a disproportionate

number of the board's enforcement cases are internally generated and against applicants, the board may not be dedicating sufficient resources to consumer complaints against current licensees.

The board indicated that it has instituted certain cost containment efforts for its enforcement program, such as case prioritization procedures, but given its impending deficit situation, the board clearly needs to take further action to reduce its enforcement expenditures. The board should explain: (1) why enforcement spending has increased, (2) what its enforcement objectives are, and (3) whether spending such a high proportion of its budget on enforcement affects its ability to carry out its other regulatory functions. Furthermore, the board should explain how it prioritizes cases, according to type and degree of harm to the consumer.

Figure 8 – Enforcement Activity

ENFORCEMENT DATA	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Inquiries (Average Per Year)	**Total: 3,000**	**Total: 13,000**	**Total: 13,000**	**Total: 13,000**
Complaints Received By Source	**Total: 461**	**Total: 450**	**Total: 342**	**Total: 310**
External (Public/Profession/Other)	66	55	55	38
Internal (Criminal convictions)	41	72	55	76
Internal (Licensee applications)	354	323	232	196
Complaints Filed By Type	**Total: 461**	**Total: 434**	**Total: 317**	**Total: 309**
Competence/Negligence	17	27	14	18
Unprofessional Conduct	67	61	18	28
Fraud	32	37	14	14
Health & Safety	55	57	24	34
Unlicensed Activity	49	67	17	25
Personal Conduct	241	185	230	190
Complaints Closed*	**Total: 500**	**Total: 221**	**Total: 351**	**Total: 440**
Compliance Actions	**Total: 11**	**Total: 23**	**Total: 17**	**Total: 31**
ISOs & TROs Issued	0	0	0	2
Citations and Fines	**	**	**	26
Cease & Desist Warnings	11	23	17	3
Investigations Commenced	**Total: 65**	**Total: 54**	**Total: 55**	**Total: 25**
Cases Referred for Criminal Action	**Total: 8**	**Total: 11**	**Total: 1**	**Total: 0**
Cases Referred to AG's Office	**Total: 58**	**Total: 63**	**Total: 47**	**Total: 61**
Accusations Filed	58	63	47	61
Accusations Withdrawn	0	0	0	0
Accusations Dismissed	0	0	0	0
Stipulated Settlements	**Total: *****	**Total: *****	**Total: *****	**Total: *****
Disciplinary Actions	**Total: 43**	**Total: 48**	**Total: 42**	**Total: 59**

Revocation	25	29	25	35
Voluntary Surrender	1	2	7	1
Suspension Only	2	0	0	0
Probation with Suspension	0	0	0	2
Probation	15	17	10	21
Probation Violations Suspension or Probation Revocation or Surrender	**Total: *****	**Total: *****	**Total: *****	**Total: *****

*May include carry-over complaints received in prior fiscal years.
**Cite and fine program implemented December 1, 1996.
***Data not reported by the board.

Disposition of Complaints

The board can respond to internal and external complaints in the following ways: dismissal, informal or formal investigation, accusation filing, and/or disciplinary action. As Figure 9 indicates, the board, on average over the past four years, formally investigated and took disciplinary action against 12 percent of complaints filed. These statistics show a steady, but slight, percentage increase in the number of cases going to formal accusation and disciplinary action. The vast majority of board disciplinary actions are taken in response to pre-licensure complaints filed by the board itself in response to applicant criminal histories.

Figure 9 – Disposition of Complaints

NUMBER AND PERCENTAGE OF COMPLAINTS DISMISSED, REFERRED FOR INVESTIGATION, TO ACCUSATION AND FOR DISCIPLINARY ACTION				
	FY 1993/94	**FY 1994/95**	**FY 1995/96**	**FY 1996/97**
COMPLAINTS RECEIVED	**461**	**450**	**342**	**391**
Complaints Closed*	500	221	351	440
Referred for Investigation	65 (14%)	54 (12%)	55 (16%)	25 (6%)
Accusation Filed	58 (13%)	63 (14%)	47 (14%)	61 (16%)
Disciplinary Action	43 (9%)	48 (11%)	42 (12%)	59 (15%)

*May include carry-over complaints received in prior fiscal years.

Case Aging Data

As the data in Figure 10 indicates, the board has taken an average of 2.5 years, over the past four years, to achieve final disposition of enforcement cases. AG timeframes for prosecuting cases appear to be a significant factor in case aging determination.

Figure 10 – Case Aging

AVERAGE DAYS TO PROCESS COMPLAINTS, INVESTIGATE AND PROSECUTE CASES				
	FY 1993/94	**FY 1994/95**	**FY 1995/96**	**FY 1996/97**
Complaint to Investigation*****	258	279	233	366
Pre- and Post- Accusation******	543	432	396	426
TOTAL AVERAGE DAYS***	**976**	**794**	**978**	**853**

*****From complaint filing to completed investigation.
******From initial request for filing formal charge to conclusion of disciplinary case.
*******From date complaint received to date of final disposition of disciplinary case.

Due to insufficient data, we are unable to provide a detailed analysis of case aging data relating to investigation and prosecution timeframes of cases. (As of the date this report was completed, the board had not provided case aging data for complaints that were sent to investigation and/or prosecution.)

Cite and Fine Program

The board's cite and fine program, which serves as a less costly administrative alternative to formal disciplinary action, has been in effect for about one year only (regulations implementing the program were adopted in December 1996). Thus, there is insufficient historical data to analyze the effectiveness of the program at this time. To date, the board has utilized cite and fine only for unlicensed practice violations. Due to the cost-effective nature of cite and fine, the board is considering increasing the use of this enforcement tool by introducing legislative changes to expand the cite and fine program to practice violations.

Figure 11 – Cite and Fine

CITATIONS AND FINES	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Total Citations	*	*	*	26
Total Citations With Fines	*	*	*	26
Amount Assessed	*	*	*	$26,000
Reduced, Withdrawn, Dismissed	*	*	*	0
Amount Collected	*	*	*	**$5,600**
*Data not available; cite and fine program implemented December 1, 1996.				

Results of Complainant Survey

The board received only 18 responses to its consumer satisfaction survey. These responses do not provide a valid result for meaningful analysis.

ENFORCEMENT EXPENDITURES AND COST RECOVERY

Average Costs for Disciplinary Cases

Average costs to investigate and prosecute cases over the past four years have ranged from $10,500 to $15,000. Expenditures on disciplinary cases appear to be split evenly between investigation and prosecution/hearing costs (see Figure 13). Based on this data, it appears that the board's cost containment efforts have met with some success since both average investigation and prosecution/hearing expenditures per case have decreased by 24 percent and 18 percent, respectively, since 1995-96.

Figure 12 – Investigation and Prosecution/Hearing Costs Per Case

AVERAGE COST PER CASE INVESTIGATED	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Cost of Investigation	$310,444	$437,160*	$405,170*	$140,129*
Number of Cases	65	54	55	25
Average Cost Per Case	$4,776	$8,095	$7,366	$5,605
AVERAGE COST PER CASE	**FY 1993/94**	**FY 1994/95**	**FY 1995/96**	**FY 1996/97**

REFERRED TO AG				
Cost of Prosecution & Hearings	$336,506	$320,088	$367,066	$393,005
Number of Cases	58	63	47	61
Average Cost Per Case	$5,802	$5,080	$7,810	$6,442
AVERAGE COST PER DISCIPLINARY CASE	**$10,578**	**$13,175**	**$15,176**	**$12,047**
***Total costs for investigations include carryovers from prior FY 1994/95 and FY 1995/96 which were reflected in FY 1996/97 costs of $634,727.				

Cost Recovery Efforts

The board has had the authority since 1987, under Business and Professions Code Section 3753.5, to recover costs associated with investigating and prosecuting enforcement cases.

According to the board, collection of cost recovery has increased 864 percent since 1993-94. Figure 13 reflects the amount of cost recovery the board has requested and received over the past four fiscal years. The improvement in the board's cost recovery efforts in the last fiscal year can be attributed in part to participation in the Franchise Tax Board's Interagency Intercept Collections Program, which allows the board to collect unpaid cost recovery from tax refunds and lottery winnings. As a result, the board collected close to 50 percent ($121,000) of cost recovery ordered in 1996-97. However, this amount represents less than 7 percent of the board's total enforcement budget, indicating that the board needs to be more aggressive in pursuing cost recovery as a means to reduce enforcement expenditures.

Figure 13 – Cost Recovery

COST RECOVERY DATA	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Enforcement Expenditures	$1,244,200	$1,137,249	$1,232,823	$1,719,693
Recovery Requested	*	*	$136,004	$297,246
Recovery Awarded	$58,220	$63,566	$126,633	$260,343
Amount Collected	**$14,293**	**$28,623**	**$45,670**	**$120,932**
*Data not available.				

RESTITUTION PROVIDED TO CONSUMERS

It appears that the board does not have a formal restitution program to collect monetary damages for patients harmed by licensee incompetence or negligence. Thus, the board did not provide any data regarding consumer restitution.

COMPLAINT DISCLOSURE POLICY

The board discloses disciplinary information upon request and in accordance with the California Public Information Act. The board releases disciplinary information to the public at the time of case referral to the Attorney General, which is prior to formal filing of accusations.

The board uses the *Respiratory Stat*, a regular board newsletter that is circulated among licensees and the medical community, to publish information on disciplinary actions taken by the board. In addition, the same disciplinary information is published in the Medical Board's monthly publication, the *Hot Sheet*.

CONSUMER OUTREACH AND EDUCATION

The board has no formal outreach or educational program for respiratory care patients. Rather, the board relies on the medical community to provide the necessary patient education regarding the role of RCPs in medical care. Consumers who call the board with inquiries or complaints are provided copies of the *Laws and Regulations Relating to the Practice of Respiratory Care* and the board's complaint form.

2.

IDENTIFIED ISSUES, RECOMMENDATIONS, AND FINAL ACTION OF THE JOINT LEGISLATIVE SUNSET REVIEW COMMITTEE REGARDING THE RESPIRATORY CARE BOARD

ISSUE #1. Should the State's licensing of respiratory care practitioners be continued?

Recommendation: ***Both the Department and Committee staff recommended the continued licensure of respiratory care practitioners (RCPs).***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: Medical patients rely on RCPs for critical services requiring professional judgment and complex, technical skills which, if performed incompetently, could cause patient harm or death. Licensure helps ensure that the practice of respiratory care by RCPs is carefully monitored, controlled, and regulated to minimize problems of incompetence and patient endangerment. The practice of respiratory care is regulated in 35 states.

ISSUE #2. Should an independent Respiratory Care Board be continued, or should its operations and functions be assumed by the Department of Consumer Affairs?

Recommendation: ***Both the Department and Committee staff recommended that the Respiratory Care Board be retained as the state agency to regulate and license RCPs. Committee staff recommended that the sunset date of the Board be extended for four years (to July 1, 2003). However, the Board should report to the Legislature within two years, on what efforts it has made to rectify its budgetary problems and revise its enforcement program. (Both of these issues are discussed further in this document.)***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: The Board has demonstrated a high level of innovation and a strong consumer protection focus. There does not appear to be any compelling reason to believe that there would be any savings or increased performance if the Board were sunsetted and its functions assumed by the Department. However, the Board must reduce expenditures

and prioritize spending to resolve its budget problems. Because of the Board's projected deficit situation and unresolved issues with its enforcement program, the Board should be required to report to the Legislature within two years on efforts it has made to rectify these problems.

ISSUE #3. Should the size or composition of the Respiratory Care Board be changed?

Recommendation: ***This Board has 9 members, of which 4 are licensed RCPs, 2 are physicians, and 3 are public members. The Department generally recommends a public member majority and an odd number of members for regulatory boards. For the Respiratory Care Board, the Department recommended that the limitations on what types of licensed practitioners serve on the Board be removed, making it easier for the appointing authorities to appoint qualified candidates. Additionally, the Department recommended that the current appointment of 3 members by the Senate, 3 members by the Assembly, and 3 members by the Governor be changed so that the Governor would make all appointments except for two. Committee staff did not agree with changing the number of appointments by the Senate and the Assembly. However, consistent with the Department's recommendation for increased public membership, Committee staff recommended removing one physician member from the Board and adding one public member. The composition of the Board would still be 9 members, but with 4 RCPs, 4 public members and 1 physician member.***

Vote: ***The Joint Committee adopted the recommendation of Committee staff by a vote of 4-0, to maintain the current appointment authority of the Senate, Assembly, and Governor to appoint 3 members each, continue with the limitations on what types of licensed practitioners must be appointed, and add one more public member and remove one physician member from the Respiratory Care Board.***

Comment: The nine-member Respiratory Care Board is a mix of licensed and public members with four RCPs, two physicians, and three public members. Under current law, the Speaker of the Assembly appoints two RCPs and one public member (3 total), the Senate Rules Committee appoints one physician, one RCP and one public member (3 total), the Governor appoints one physician, one RCP and one public member (3 total). The appointment authority for this Board is different from that of other boards under the Department of Consumer Affairs. Generally, all other boards allow for only one member to be appointed by the Assembly and one by the Senate. The Department is recommending a change in the appointing authority so that it is consistent with "normal Executive Branch structure and the regulatory structures of the other 27 boards within the Department." No other justification is given. Initially, when the RCP was created in 1983, the equal appointing authority was seen as an experiment. The Board has found the mix to work very well, and it appears that having three different authorities seems to lessen the burden of filling vacancies and lessens the time delay between appointments. The only two appointments which have been delayed are those of the Governor's office. The physician member appointment has been vacant since June 1, 1996. Previously, the

RCP director position went unfilled from June 1, 1991 to March 9, 1994. There appears to be no reason to make this change.

The Department is also recommending that the limitations on what types of licensed practitioners must be appointed to the Board be removed. Currently, one of the RCPs must be a technical director of a respiratory care department or respiratory care corporation, one must be an officer or faculty member of a school or institution engaged in respiratory therapy education, and two must be involved in direct patient care. One of the reasons for specifying the types of RCP practitioners was to ensure that RCP appointments would be from various areas of actual practice and not be all educators or directors with no actual practice experience. Neither the Assembly nor the Senate have experienced problems in making their three (3) RCP appointments. There does not appear to be any justification for making this change since the Governor only appoints one of the RCPs.

The Department generally recommends having a public member majority and an odd number of members on occupational regulatory Boards, or at least achieving greater representation of the public where current Board composition is heavily weighted in favor of the profession. Since the Board's primary purpose is to protect the public - and there have been problems in the past, and continue to be problems, with the public's perception of boards in performing their consumer protection role - increasing the public's representation on this Board assures the public that the profession's interests do not outweigh that of the Board's, in protecting the public from incompetence or unlawful activity on the part of RCPs. *Requiring closer parity between public and professional members* is also consistent with both the Joint Committee's and Department of Consumer Affair's recommendations regarding other boards that have undergone sunset review.

ISSUE #4. Should the Board seek a fee increase to improve its budget situation?

Recommendation: ***Both the Department and Committee staff agreed that the Respiratory Care Board has experienced major fiscal problems and may need to seek a fee increase, but only after providing appropriate justification to the standing and appropriation committees of the Legislature. However, prior to implementing the increase, the Board should also explore additional means of balancing revenues and expenditures, including curtailing programs and services that are not mandatory. In addition, the Board should restructure its enforcement program and prioritize enforcement spending.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 5-0.***

Comment: The Respiratory Care Board will have a projected fund deficit of $320,000 by the end of the 1997-98 fiscal year. In addition, the Board owes the Attorney General (AG) $246,000 for services performed in 1994-95 and 1995-96. The Board attributes this situation primarily to increased enforcement costs related to a surge in disciplinary cases and the transfer of $785,000 from the Respiratory Care Fund to the General Fund in 1991-92. Specifically, the Board notes that the costs of administrative hearings and hourly rates for AG prosecution services have increased significantly over the past few years. In response, the Board has implemented several cost-saving measures, including holding positions open and streamlining case preparation for submittal to the AG.

The Board will have to take a number of steps to resolve its fiscal crisis. Increasing license renewal fees should be among them. The Board's last fee increase was in 1994. However, a fee increase alone will not address the Board's structural budget problem—expenditures exceeding revenues. Therefore, the Board should consider restructuring and curtailing its enforcement program and reducing discretionary activities. The high costs associated with conducting rigorous background checks, and disciplining applicants and licensees for prior criminal violations, raise a question of whether they should be continued. (This issue is further discussed in Issue #5.)

To balance its budget, the Board needs to strike a balance between proactive enforcement efforts and cost containment. Prior to implementing a fee increase, the Board must demonstrate additional reduced expenditures and improved program efficiencies. Additionally, the Board should restructure its enforcement program and prioritize enforcement spending.

The Board should report to the Legislature on a comprehensive budget plan that will bring spending in line with resources in the near term and over the longer term. Despite the fact that the Board anticipates reduced enforcement costs due to higher entry for applicants, the Board's ultimate goal should be achieving overall fiscal health. For instance, the Board should maintain a prudent reserve of three months operating costs. To accomplish this, the Board must reduce program activities, increase fees, or a combination of both.

ISSUE #5. Should the Respiratory Care Board restructure its enforcement program? Should the current Board's practice of disciplining applicants and licensees for prior criminal convictions be continued?

Recommendation: ***Both the Department and Committee staff recommended that the Board prioritize its enforcement spending and only take disciplinary action against those applicants and licensees who exhibit incompetence, and have committed criminal offenses that are substantially related to the ability to practice respiratory care.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: While the Board's proactive approach to enforcement, such as drivers' records checks for alcohol-related offenses (which is unique to this Board) and criminal background checks is commendable, the Board should be more judicious with spending on enforcement and initiate disciplinary action on a selective basis. The Board's spending on enforcement—almost 84% of its total budget—is the highest among all boards under review this year

It is not clear what the consumer protection benefits are from pre-licensure disciplinary action against individuals with prior criminal histories for personal conduct violations that may not relate to competence. While the Board's goals in this area are laudable, the current budget situation requires that the Board cut costs. Maintaining staff to conduct extensive background checks and to discipline for past violations is costly, and, perhaps, excessive. Until spending is in line with revenues, the Board will have to curtail activities and further prioritize enforcement spending.

The Board should explain (1) why enforcement spending has increased, (2) what its enforcement objectives are, and (3) whether spending such a high proportion of its budget on enforcement affects its ability to carry out its other regulatory functions. Furthermore, the Board should explain how it prioritizes cases according to type and degree of harm to the consumer, to ensure the effective use of its enforcement resources.

ISSUE #6. Should the Respiratory Care Board, as it has recommended, be allowed to initiate a pilot program for temporary license suspension orders in situations of alleged misconduct?

Recommendation: ***The Department does not support the establishment of a pilot project to temporarily suspend a license without the protection of due process. It indicates that the Board has not adequately demonstrated that it is using the authority it already has (use of the administrative Interim Suspension Order (ISO) or the judicial Temporary Restraining Order (TRO)), and that any exceptions to the Administrative Procedure Act could be used as precedents and must be approached with extreme caution. Committee staff agreed and has already recommended a pilot program for the Medical Board to determine if a more immediate procedure is***

necessary to suspend a practitioner's license.

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: The Board recommended that it be given statutory authority for automatic temporary license suspension in cases of suspected misconduct. Under existing law, the Board first must obtain an ISO or TRO, a costly and lengthy process that usually allows licensees under investigation to continue working until an administrative law judge or court grants a license suspension order (in one case, over five months). However, the Board has only issued two ISOs in 1997, and for the past four years has requested three ISOs, but then did not proceed with having them issued because the Attorney General expedited hearings on those cases. At this time, there does not appear to be a need for this Board to be granted special authority to suspend a license, nor would this Board be a good test case for examining the use of simplified procedure for suspending a license as recommended for the Medical Board.

ISSUE #7. Should respiratory care registry companies be required to register with the Board?

Recommendation: ***The Department recommended that further data be provided to support the Board's recommendation for requiring registration of registry firms. The Department could not determine the extent of the problem created by the registries or whether requiring these firms to register is warranted. The Department further recommended that the Board conduct a sunrise process prior to proceeding with an expansion of regulation. Committee staff concurred with this recommendation.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: The Board recommended that registry firms that offer contract respiratory care services be registered with the Board to combat unlicensed practice. Currently, the only requirement for these firms is that they register with the Secretary of State. The Board indicates that the proposed registration requirement is modeled on the Board of Pharmacy's retailer registration requirement. Information obtained from the Board indicated that registry firms provide RCPs and/or respiratory care services to hospitals.

Both the Department and Committee staff need more information on the types of complaints and the extent to which registries are using unlicensed personnel to perform respiratory procedures. Even then, it is not clear what action the Board could take if only registration is required, since unlicensed practice is a misdemeanor and subject to criminal penalties. If there are issues involving billings and medical fraud, this may be outside the purview of this Board. In any case, the Board should submit such a proposal with appropriate justification to the sunrise review process (Section 9148 et seq. Gov. C.)

ISSUE #8. Should the Respiratory Care Board be authorized to require mandatory reporting from any employer of a respiratory care practitioner if they terminate an RCP for cause (criminal misconduct, negligent practice, etc.), and from a licensee who knows or has reason to believe that an RCP has violated any statutes or rules administered by the Board?

Recommendation: ***The Department recommended that further data be provided to support the Board's recommendation to require mandatory reporting. Committee staff concurred with the Department.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: In an effort to expedite the disciplinary process, the Board recommended that employers and licensees be required to report to the Board the termination for cause of any RCP, or suspected misconduct by any RCP. In support of this recommendation, the Board cited one case in which RCP negligence leading to the death of a patient was not reported to the Board until almost two years after the fact. Both the Department and Committee staff cannot determine how pervasive this problem is, and whether requiring mandatory reporting is warranted for this Board. The Board should provide appropriate justification including a cost/benefit analysis.